Beth Israel Deaconess Medical Center, Boston, MA
INPATIENT LAB REGISTRATION

(Please Print)

Medical Record Number:	Account Number:	Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: Spouse's first name:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐
Birth Date: / /	Sex/Gender: ☐ M ☐ F	Street Address: Apt or Unit:			City: State/ Country / Zip: / /
Social Security no: - -		Home Phone no: ( ) Other Phone: ( )			Work Phone: ( )
Mother's First Name:			Father's First Name:		
Race/Ethnic Background - Please indicate:					
Primary Care Physician (PCP):			PCP Phone Number:		
PCP Address:					
Referring Physician			Referring Physician Phone Number:		
Next of Kin:			Next of Kin Phone:		
Next of Kin Address:					

Inpatient Institutional Billing Information

(Please fill out all fields.)

Name of Institution:		
Provider Identification Number:		
Billing Contact Name:	Phone Number:	Email Address:
Billing Address:		